Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service, 01/07/02.
   b. The request was received on 03/21/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial TWCC 60
      1. EOBs/Audit dated 02/18/02
      2. HCFAs-1500
      3. Letter to Compliance and Practice dated 03/20/02
   b. There is no response to the request for additional documentation found in the file.
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome

2. Respondent, Exhibit II:
   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/11/02. There is no Carrier initial or 14 day response to this medical fee dispute in the file.

III. PARTIES' POSITIONS

1. Requestor: 03/13/02:
   "We take pride in the thoroughness of our documentation process….Enclosed are preauthorization requests and approvals from your company…. The carrier states, 'Based on the TWCC TRMT Guideline's ground Rule 2,A, I-VII change in the patient's clinical condition and/or progression has not been documented to support 1:1 therapy. Patient's condition supports therapy in a group setting.' *How can the carrier ask us to leave this man by himself to do a strenuous workout in the pool when he is experiencing numbness in this left leg?*….As for CTP Code 97110, we cannot change CPT codes after they have been preauthorized by the insurance carrier….The carrier is denying payment according to Fee Guidelines yet if they would read the MFG on page 32, A (9)(b) states that Procedures (Supervision by the doctor or HCP, in either a group (97150) or one to one (97110-97139) setting, is required. If you would also care to look at page 59 you will see that the MAR for CPT code 97110 is $35.00 per unit….The SOAP note clearly states exactly what was done with the patient and therefore should be reimbursed accordingly. This patient had a severe disc lesion, which caused him to have weakness in the knees and balance problems. He had neurological problems such as dizziness. The doctor needed to be there at all times doing one-on-one care to avoid drowning. For this

reason the patient had one on one care given to him during his aquatic exercises. The procedure is clearly documented in the SOAP notes submitted originally with the claim on that date of service….We have now started to videotape the procedure….The time is documented by the minute….The documentation is over a 300-word essay on what went on during that hour. Open-heart surgery for several hours does not require that much documentation. The carrier is denying payment according to Fee Guidelines….Our documentation states that one on one care was given to the patient and it also indicates why it was given….We are consistent with the documentation we submit. We never had any problems with our documentation in the past. We are not sure why the carrier is now saying that it is not sufficient….Both in the Spine treatment guidelines and the Lower Extremity treatment guidelines the Treatment interventions include 1) **Attended modalities and procedures.** Therefore, I believe we complied with the Treatment guidelines."

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only (DOS) eligible for review is 01/07/02.

2. The amount billed per the TWCC-60 is $19.00.

3. The amount paid by the Respondent per the TWCC-60 is $0.00.

4. The amount in dispute per the TWCC-60 is $19.00.

6. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

V. RATIONALE

Medical Review Division's rationale:

The Requestor submitted a HCFA-1500 reflecting charges for CPT Code 99080. CPT Code 99080 is a DOP and defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

The carrier has denied the charges in dispute as "F – REIMBURSEMENT IS NOT ALLOWED WITHOUT THE REQUIRED DOCUMENTATION OF PROCEDURE AS DEFINED IN THE 04/01/96 TWCC MEDICAL FEE GUIDELINE, PAGE 1." The re-audit dated 02/18/02 states, "The information submitted with the appeal does not include a substantive explanation as to why the bill is being appealed per TWCC Rule 133.304 (k). The (Carrier)'s original position remains the same." The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. Therefore, **no** additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 26th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.